



Texas Department of Insurance

Division of Workers' Compensation

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

Respondent Name:

TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number:

M4-12-1027-01

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Carrier's Austin Representative Box

Box Number 01

MDFR Received Date

DECEMBER 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in letter to Creative Risk Funding dated October 13, 2011: "As you are aware I suffered an occupational injury this April in connection with my job responsibilities as an Instructor at Tomball ISD. Please be advised I have incurred out of pocket expense totaling \$918.59 due to this injury and have attached these receipts for your consideration..."

Amount in Dispute: \$918.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This claim involves an injured employee's reimbursement for healthcare paid under Division Rule 133.270. By way of history, [injured employee] sustained a compensable low back strain and left hip strain injury in the course and scope of her employment on April 1, 2011. She elected to use her personal insurance to obtain treatment for her compensable injury. After her handling adjuster informed of the repercussions associated with her decision, she voluntarily signed an election of remedies statement on August 25, 2011. Despite the fact that [injured employee] has never demonstrated a desire or willingness to pursue health care under the provisions of the Texas Workers' Compensation Act, Self0Insured nonetheless acknowledges liability for those medical expenses that [injured employee] incurred prior to making a formal election of remedies on August 25, 2011. However, [injured employee] would still bear the burden of proving that the expenses for which she is seeking reimbursement are related to her compensable injury..."

In summary, Self-Insured has processed [injured employee's] reimbursement request to the extent it is able to do so and awaits additional information from her that will allow it to fully respond to her reimbursement request while remaining compliant with Rule 133.270(g)."

Response Submitted by: Creative Risk Funding, 8111 Lyndon B Johnson Freeway, Ste. 795, Dallas, TX 75251

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2011 through July 27, 2011	Out-of-Pocket Expenses – ER visit; Hospital Co-Pay; Office Visits; Physical Therapy sessions; and Prescription Medications	\$918.59	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 20, 2011, July 10, 2012; September 20, 2012; September 25, 2012; and January 9, 2013

- A0 – Patient refund amount.

Issues

1. Did the requestor submit the out-of-pocket expenses for the services in dispute timely and in accordance with 28 Texas Administrative Codes §§133.307 and 133.270?
2. Did the respondent submit documentation to support the disputed bills were reimbursed in accordance with 28 Texas Administrative Codes §§134.1 and 134.203?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted the request for medical fee dispute resolution In accordance with 28 Texas Administrative Code §133.307. This dispute will be reviewed in accordance with the Texas Labor Code and Division Rules.
2. The respondent submitted EOBs and copies of checks showing the injured employee was reimbursed for out-of-pocket expenses incurred by the injured employee for treatment of the compensable injury in accordance with 28 Texas Administrative Codes §§134.1 and 133.270. The check numbers and amounts are as follows:
 - Check number 195592 was issued December 21, 2011 in the amount of \$73.59 for out-of-pocket expenses paid for prescription medications paid to Walgreens for dates of service April 12, 2011, April 20, 2011, June 22, 2011, June 24, 2011, July 7, 2011.

- Check number 195594 was issued December 21, 2011 in the amount of \$99.60 for the emergency department visit of April 11, 2011. The injured worker paid Neptune Emergency Services, PA, Methodist Willowbrook Hospital – ER Physicians a total of \$295.00. The insurance carrier made payment to the injured employee according to 28 Texas Administrative Code 134.203 - Medical Fee Guideline for Professional Services. Therefore no further reimbursement is recommended.
 - Check number 202915 was issued July 10, 2012 in the amount of \$200.00 for out-of-pocket expenses paid to Select Physical Therapy for dates of service June 27, 2011, June 30, 2011, July 5, 2011 and July 27, 2011.
 - Check number 205136 was issued September 25, 2012 in the amount of \$150.00 for out-of-pocket expenses for treatment/services at the Methodist Willowbrook Hospital Emergency Department for date of service April 11, 2011.
 - Check number 208993 was issued January 9, 2013 in the amount of \$200 for out-of-pocket expenses paid by the injured worker for office visits at the Kelsey-Seybold Clinic for dates of service April 6, 2011, April 20, 2011, May 25, 2011, June 22, 2011 and July 27, 2011.
3. The respondent has submitted the above documentation to support the disputed out-of-pocket expenses incurred by the injured worker has been reimbursed.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2013 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.